DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	456 W MARKET ST WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	**INITIAL COMMENTS** This visit was for the post certification revisit (PCR) to the annual recertification and state licensure survey completed on 5/23/2014. This visit was in conjunction with a PCR (Post Certification Revisit) to the investigation of complaint #IN00151222 completed on 7/11/2014. Dates of Survey: August 14 and 15, 2014. Provider Number: 15G033 Facility Number: 000593 AIM Number: 100233360 Surveyor: Susan Eakright, QIDP Pathfinder Services, Inc. was found to be in compliance with 42 CFR, Part 483, Subpart I, and 460 IAC 9 in regard to the PCR to the recertification and state licensure survey. Quality Review completed 8/20/14 by Ruth Shackelford, QIDP.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE